# CHAPTER I – OVERVIEW AND ADMINISTRATION

## 1.01 Long Term Support In Wisconsin

The Medicaid Home and Community-Based Services Waiver programs were authorized by Congress in 1981 and began in Wisconsin in 1983 with the Community Integration Programs. The Medicaid Waivers were a significant step taken to mitigate the Medicaid program's institutional bias that had led to the extensive development and utilization of nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), also called Facilities for the Developmentally Disabled (FDDs). Recognizing the problem as well, Wisconsin had taken its own steps to reverse the trend toward institutionalization with the creation of the Community Options Program (COP).

Created in 1981, COP was developed to provide eligible persons a safe community alternative to institutional placement. In addition, COP was designed to bring a system of care management and service coordination to the complex world of community services while placing the consumer in the center of the service planning process. The program intent is to forge a working partnership between the participant and the Care Manager or Support and Service Coordinator, in which they jointly develop a plan that addresses the participant's identified needs and meets her/his desired individual outcomes. While keeping the participant's preferences in mind, the Care Manager or Support and Service Coordinator, participant and other team members seek the most cost-effective means to meet those individual outcomes in an integrated community setting.

The Medicaid Waiver programs are built upon a foundation of primary program values. These values support individual choice; the enhancement of relationships; the building of accessible, flexible service systems; the achievement of optimum physical and mental health for the participant; and the promotion of presence, participation and optimal social functioning in the community. The program values further seek to ensure that participants are treated with respect and assure that service systems empower the individual, build on their strengths, enhance individual self-worth and supply the tools necessary to achieve maximum independence and community participation.

Today there are five long-standing statewide Medicaid Home and Community-Based Services Waiver programs operating in Wisconsin. These programs are:

- Community Integration Program IA (CIP IA)
- Community Integration Program IB (CIP IB)
- Community Integration Program II (CIP II)
- Community Options Program Waiver (COP-W)
- Brain Injury Waiver (BIW)

In addition, three separate Waivers serving three distinct, federally-defined target groups of children were approved on November 20, 2003 by the Centers for Medicare and Medicaid Services (CMS). These three Waivers serve children with developmental disabilities, children with severe emotional disturbances and children with physical

Disabilities. The Children's Waivers match the eligibility criteria for the Family Support Program offering the opportunity to match these state funds to federal funding under the Waivers. Taken together these Waivers represent the initial implementation of the Children's Redesign Project. These Waivers are referred to as the Children's Long Term Support (CLTS) Waivers in this Manual.

In addition, there are several other community-based Waiver programs serving similar populations. These include the Family Care program and PACE/Partnership projects. Family Care and the Pace/Partnership programs are not covered by this Manual. Generally speaking, the individual community Waivers programs serve distinct populations, providing the primary financial foundation for the provision of comprehensive, community-based services.

This Manual covers only the following Waivers:

- Community Integration Program IA (CIP IA)
- Community Integration Program IB (CIP IB)
- Brain Injury Waiver (BIW)
- Children's Long Term Support Waivers[1]

Policies described in this Manual are grounded in state statutes, Department of Health and Family Services' administrative code, and the provisions contained in the Waiver applications submitted to and approved by, the Centers for Medicare and Medicaid Services (CMS). County decisions about the local administration of the community Waiver programs must be based on policies and procedures specified in the county's COP Plan.

**1.02 - Reserved**

**1.03 The Medicaid Waiver Mandate**

Regular COP funds may not be used for long-term support services that could be funded under one of the Medicaid Home and Community-Based Services Waiver programs. The Waiver mandate is intended to increase the total resources available to participants while maximizing the use of federal funds to support the provision of community-based services. Whenever possible, a child participating in both the Family Support Program (FSP) and a CLTS Waiver should use FSP funds to match federal funds under the Waiver. However, a county is not obligated to utilize the Waiver to serve each child receiving FSP funds. Additionally not all services permitted under FSP are covered under the CLTS Waivers.

[1] The CLTS Waivers serve children with developmental disabilities, children with severe emotional disturbances and children with physical disabilities. The CMS officials required that Wisconsin submit three separate Federal Waiver applications, one for each target group. The regulations between the three CLTS Waivers are identical, unless otherwise noted.

A. Application of Waiver Mandate Related to COP Funds:

Waiver funds must be used when:

1. The participant is eligible or becomes eligible for the Waivers; and
2. The agency has Medicaid "Waiver resources" available; and
3. The services to be provided are covered by the Waiver.

The mandate does not apply when:

1. The person does not meet the Medicaid Waivers level of care requirements, or;
2. The person does not meet Medicaid financial eligibility requirements, or;
3. The person does not meet other program eligibility requirements including alien residency status or target group or;
4. The person is under age 65 and has been denied a disability determination; or is aged 22-64, and has a severe and persistent mental illness and is not otherwise considered appropriate for admission to or care in a nursing home or an ICF/MR at a level of care reimbursable by Medicaid, or;
5. The person's preferred living arrangement is appropriate to meet his/her needs but is not in a living arrangement allowed under the Medicaid Waivers (see Chapter III, Section 2.01).

B. Availability of Resources:

Medicaid Waiver resources are considered to be available if:

- The agency has an unused CIP 1A, CIP 1B state-matched slot or funds that can be designated for funding a locally-matched slot in CIP 1B or BIW for which the participant is eligible; or,
- The agency has regular COP funds available to match available Medicaid community Waiver slots, thus applying the mandate to those funds as well.

C. Exemptions from the Mandate:

Persons exempt from the Waiver mandate in addition to persons who are not eligible for Medicaid include:

1. Any person for whom a Medicaid Waiver application is being processed is exempt for up to 90 days, provided that within the first ten days after services are initiated:

- a referral is made to Economic Support for a Medicaid application (unless the person is already receiving Medicaid), and
- Waiver program functional eligibility is established; and
- an initial individual service plan is completed.

2. Any person whose total state share of costs under COP would be less than the state share of costs under the Medicaid community Waiver. Documentation of this exception must be placed in the participant's record.

3. Any person whose total cost of care for COP-funded services is less than $100 per month may be exempted with no cost-effectiveness documentation required.

4. Any person who will receive services (other than Care Management or Support and Service Coordination) or equipment that is not allowed by the Waivers.

5. Any single parent of minor children whose income places them in Category C, (medically needy) using the Medicaid Waiver cost-sharing worksheet (refer to Form DDES 919 (Appendix A)) or Client Assistance for Re-employment and Economic Support (CARES).

6. Persons who meet the hardship criteria and are exempt from participation in the Medicaid Purchase Plan (MAPP).

**Note: Any person exempt from the Waiver mandate may still apply for Medicaid State Plan (Medicaid card) services.**

## 1.04 Registering Potentially Eligible Applicants Who Are Not Funded

County agencies are required to register applicants of any age who, based on a preliminary review of functional and financial eligibility, are likely to meet the criteria for Medicaid Waivers participation but who were not yet receiving funding. Registration is completed on the Long Term Support Module of the Human Services Reporting System (HSRS). Persons registered on HSRS include those who are:

- currently in an institution and who request Medicaid Waiver services;
- currently receiving no publicly funded community-based long-term care services; or
- currently receiving some publicly funded community-based long-term care services, but not from COP or Medicaid Waivers.

The purpose of HSRS registration is to have a statewide database containing standardized information that may be used to do effective program planning. Persons already receiving COP or Medicaid Waiver funded services are not to be registered on HSRS even if they have unmet service needs.

## 1.05 Waiting Lists

A. Placement on Waiting Lists .

1. Assessments and Individual Service Plans: The only permissible circumstances in which a waiting list for assessments and individual service plans may be

established is when the agency has expended all funds available for assessments and care plans. Any applicant denied an assessment or an individual service plan for this reason must be provided the opportunity to be placed on a waiting list for assessment or individual service plan development.

2. Services: The only permissible circumstances in which a waiting list for services may be established are when the agency has:

   a. determined that the cost of meeting the community services identified in the assessment will cause the agency to exceed state and federal funds available (service funds are available if they have not yet been expended or committed to current participants); or

   b. established a waiting list for the target group of which the applicant is a member for the purpose of meeting minimum significant proportions requirements for other target groups when the only source of funds available for match is COP funds.

**NOTE: Any eligible applicant or current participant who is denied services for the reasons described above must be provided the opportunity to be placed on a waiting list for services.**

B. Procedures for Placing Persons on Waiting List

The county agency must establish policies and procedures for creating and maintaining waiting lists for Medicaid community Waiver services when program funding cannot be accessed because all available Waiver resources/slots are expended or obligated. The following procedures must be used when placing applicants on the local waiting list for services:

1. The agency shall make a preliminary determination of financial and functional eligibility, as well as the need for long-term care services.

2. The agency shall document the contact with the applicant, or other referral source, and the date of placement on the waiting list.

3. The agency shall make an offer of an assessment which, if accepted, must be completed within 45 days or, if the applicant agrees, delay the assessment until a time nearer to when funds for Medicaid Waiver services will become available.

4. The agency shall update the waiting list every six months and provide each applicant/participant placed on the waiting list with a notification of her/his status on the waiting list as well as an estimate of when funding for services may become available.

5. The agency shall ensure that participants from another county who move into the county are placed on their waiting list for services while funding for their service plan from their county of origin continues.

C. Establishing Policies and Procedures for Serving Persons from the Waiting List

The agency or agencies providing services in any of the Waivers covered in this section must have a written policy that is county-wide in scope and addresses how persons from waiting lists will be served. This policy shall be included in the county's adopted Community Options Plan. The policy must comply with the following standards:

1. The policy for serving persons from the waiting list must be fair and equitable and must ensure movement of individuals on the list at a reasonable pace.

2. The policy may not prioritize applicants on the basis of level of funding needed or because the prospective Waiver participant has recently moved to the county.

3. All services needed to assure a current Waiver participant's health and safety must be provided and funded. Counties may not place people on waiting lists or create waiting lists for services needed to address assessed health and safety needs.

4. The decision to increase or add services to a participant's plan must be based on assessed need. Individuals who are currently served may be given priority for the allocation of additional resources if this provision is adopted in the county's COP Plan. Such a priority waiting list is no longer required.

5. County agencies may establish local priorities for serving specific groups of prospective Waiver participants off the waiting list. These can distinguish current from new participants or be defined by some common functional element (such as person who unexpectedly loses their natural support). These priority groups must be included in the county's adopted Community Options Plan and must be approved by the county Long Term Support Committee. If local priorities are established, these must be adhered to and shared with the county's assigned Community Integration Specialist (CIS).

6. If the resources available are not sufficient to fund all of the needed services identified in the assessment of the next person on the county's waiting list, the county may provide the funding for some of the services needed by the individual. Services funded must address an assessed need. Under no circumstances shall partial funding be permitted if the resulting plan does not adequately assure the individual's health and safety.

7. If the partial funding for a new Waiver participant is not sufficient to permit the county to assure the person's health and safety, the county must preserve these funds for use by that person until the total funds available are sufficient to adequately address the person's health and safety needs. Counties may use these funds for nonrecurring, one-time costs, or may carry them over so long as they do not exceed the county's carryover limit.

8. The person who receives funding for only some of the needed services shall maintain his/her position on the waiting list until all of the services and supports needed to address the assessed needs are provided.

9. When a Waiver participant currently receiving services under an approved plan:
   - moves to a different county;
   - is currently being funded by the county **from** which he or she moved;
   - is the next person on the waiting list in the county **to** which he/she moved; and,
   - some of the resources needed for the person's plan become available in his/her new county of residence;
     BUT
   - these resources are insufficient to fully fund all services in the plan;
     THEN:
   - the county **to** which the person moved shall apply these resources and partially fund services for this person; and
   - the county **to** which the person moved shall accept program responsibility for this person and open this person on HSRS as the county of responsibility.

     AND
   - The county **from** which the person moved that previously provided all of the funding for the person shall continue to provide the remaining funding needed to finance the person's current plan until the new county is able to take over all funding.

   See Chapter 2, Section 2.08 of this Manual for information about funding and inter-county moves.

10. A prospective Waiver participant on a waiting list may not be skipped over because the resources that became available are earmarked for a specific service or provider. As provided in chapter IV, Section 4.03, the agency administering the Waiver may not limit the pool of qualified providers by offering an exclusive contract that ear-marks funds for this provider. Waiver funding is to follow the individual so that the next person on the waiting list can use the resources in a manner that addresses his/her needs.

## 1.06 Granting Exceptions to Waiver Requirements

Exceptions to any requirement in this Manual may be granted unless state law or administrative code governs the requirement. County staff or their designated agents must request any exception in writing in the format described in this section. Requests shall identify:

- the nature of the exception being sought;
- the alternative way the matter will be handled;
- the reasons why the proposed exception is superior to using the method required in this Manual; and

- an explanation of how the exception requested meets the criteria for granting exception listed below.

Department staff shall respond to the request within sixty (60) days of receipt of the request.

An exception may be granted only when the request meets **all** of the following criteria:

1. strict enforcement of the requirement would result in unreasonable hardship or unnecessary expense for the county, provider or Waiver participant;

2. granting of the exception does not jeopardize Waiver participant health, safety or welfare, or violate the participants rights;

3. the subject of the exception does not violate laws or administrative rules governing the Waivers or community services in general;

4. granting the exception is necessary to continue to serve the person in the community and without the exception, the person would be at higher risk of institutionalization; and

5. granting the exception creates a situation which is equivalent or superior to the situation that would be present without the exception.